STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING B. WING	01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVEN SENT HOME HEALTH CARE LLC	10484 N STATE ROAD 13, ELWOOD, IN, 46036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Care Agency. Survey Dates: 1/18, 1/19, 1/20, 1/21, and 1/24/2022 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR by Area 3 on 1/31/2022	G0000		2022-02-08
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health agency. Survey Dates: 1/18, 1/19, 1/20, 1/21, and 1/24/2022 QR by Area 3 on 1/31/2022	N0000		2022-02-08
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review, interview, and	G0528	G-0528 The clinical staff educated/in-serviced on G-528 and policy 2.05 to include a	2022-02-08

	observation, the agency failed to ensure the comprehensive assessment accurately reflected the patient's hearing status, psychosocial status and functional capacity within the community; impact on the delivery of services; ability to participate in their own care; and failed to ensure assessments accurately reflected the cognitive status of patients and their ability to understand, remember, and participate in the development and implementation of their plan of care in 1 (patient 3) of 3 home visits made. Findings include: Review of an agency Policy titled "Comprehensive Assessment Policy #: 2.05," stated, "A review of an agency's policy number 2.05 titled, "Comprehensive Assessment", dated 12/10/2019 revealed, "Purpose: Comprehensive assessment must be .... consistent with the client's immediate needs ... Assessment of the clients current health status include relevant past medical history as well as all active health and medical problems & Client Goal is defined as client-specific objective, adapted to each client based on the medical diagnosis, Doctor's order, comprehensive assessment, client input, and specific treatments provided by the agency." Measurable outcome is change in health status, functional status, which occurs over time in response to health care intervention. This may include: end-result functional and physical health improvement/stabilization ... Because of the nature of the change can be negative or neutral, the actual change in health status can vary from client to client, ranging from decline, no change, to improvement in client condition or functioning. The client's continuing need for care there is no limit on time the client is eligible for Home health care, therefore, the comprehensive assessment must clearly demonstrate the need, eligibility, for the home care benefit. The clients medical, nursing, rehabilitative, social, and discharge planning needs must be presented at each 60 day encounter or sooner if changes in health status." Review of an agency document titled "Case Conference," dated 1/4/2022, section titled "Notes" contained a handwritten entry, "Client called office voiced concerns about medications and knowing she is not taking them correctly. Educated client on importance of taking medications as prescribed, encouraged med set up by SN once weekly. [He/she] verbalized understanding and agreed to same. Will discharge from non-skilled and admit to Skilled care. MD aware."		complete health, psychosocial, functional and cognitive status on the comprehensive assessment All records cited at survey have been corrected 100% of clinical records were reviewed if needed verbal or notification orders were obtained and sent to physician for clarification. A section was added to our audit tool for a complete health assessment to ensure accuracy Clinical staff were counselled on G-528 and Policy 2.05 100% of new admissions and recertification will be audited for adherence to this standard deficiency. Clinical Director and Administrator will review audits x 2 months to implement any changes Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

Review of the clinical record for patient 3 contained a plan of care with a start of care date of 11/29/2021, with a recertification period of 1/5 to 3/5/2022, with diagnoses including, but not limited to: Coronary Artery Disease (CAD - reduction of blood flow to the heart muscle due to build-up of plaque in the arteries of the heart), Diabetes Type 2 (DM - a chronic condition that affects the way the body processes blood sugar), and anxiety. Patient 3's plan of care orders included HHA (Home Health Aide) services 2 hours per day, 2 days per week for 9 weeks and Skilled Nurse visits 1 hour a day once a week for medication set-up.

Review of a comprehensive assessment dated 1/5/2022, evidenced patient #3 "lives alone with no available caregiver ... [spouse] passed away August of 2021, and [patient 3] has bouts of anxiety and depression ... being treated for this with medication and reports that they do help some. [Patient 3] is alert and smiles with appropriate conversation ... adds to conversation and is engaged in what we talk about. Cognitive: [patient 3] expresses complex ideas, feelings and needs clearly and completely with no impairment ... sugars are well maintained ... checks [his/her] {blood sugar levels} weekly ... uses oral medication and diet to control sugars ... Client verbalizes that [he/she] knows [he/she] misses some of medications and does not take them as prescribed ... All diagnoses are controlled with medications and/or treatments. Strength is [patient 3] is a motivated learner and compliant with MD orders. Weakness is depression and anxiety and loss of [patient's spouse]. Client's goal for this care period is to have no falls."
The clinical record failed to evidence documentation of patient #3's deficits in relation to his/her hearing and ability to effectively manage his/her medications, as evidenced by missed doses of medication, and therefore was not an accurate complete assessment.

In an interview on 1/20/2022 at 2:35 PM, with the clinical manager, the clinical manager indicated believing patient 3 did not have cognitive issues, vision issues, or manual dexterity issues, and stated patient 3 had missed a few doses of ordered medications.

	In an interview on 1/20/2022 at 3:50 PM, with the alternate clinical manager, the alternate clinical manager indicated patient 3 had cognitive issues, and queried the surveyor, you don t think she has cognitive issues,? to which the surveyor indicated based on review of the Comprehensive Assessment for the current certification period, there was insufficient documentation to establish a basis for a determination patient #3 had cognitive impairment. The alternate clinical manager indicated patient 3 was hard of hearing, and verified this was not documented in the comprehensive assessment. A home visit for patient 3 was conducted on 1/20/2022 at 9:30 AM. Although patient 3 was aware of the pending visit, upon arrival to the patient's home, the clinical manager made two attempts to contact the patient by knocking on the door and calling out for the patient by name through a screen door. The clinical manager was eventually able to reach patient 3 by telephone, who then came to the door to allow entrance into the home. Surveyor introduced self to patient 3 and thanked patient for allowing surveyor to attend the visit. Patient 3 looked directly at the surveyor, and smiled (patient squinted eyes while donning a surgical mask), patient 3 did not acknowledge formal greeting with a proper response. The surveyor and clinical manager had to raise their voices to communicate with patient 3 throughout the visit. The purpose of the skilled nurse visit was for weekly medication planner set up only and Patient 3's medications were refilled. IAC 17-114-1(a)(1)(A)			
G0532	Continuing need for home care 484.55(c)(3) The patient's continuing need for home care; Based on record review, interview, and observation, the agency failed to ensure the comprehensive assessment demonstrated the continuing need for the home health services in 1 (patient 3) in 3 patient home visit observations made. Findings include:	G0532	G-0532 The clinical staff educated/in-serviced on G-532 andpolicy 2.05 for the patients continuing need for home care All records cited at survey have been corrected 100% of clinical records were	2022-02-08

	Review of an agency Policy titled "Comprehensive Assessment Policy #: 2.05," stated "Purpose: Comprehensive assessment must be .... consistent with the client's immediate needs, ... Assessment of the clients current health status include relevant past medical history as well as all active health and medical problems ... Measurable outcome in change in health status, functional status, which occurs over time in response to health care intervention. This may include: end-result functional and physical health improvement/stabilization ... Because of the nature of the change can be negative or neutral, the actual change in health status can vary from client to client, ranging from decline, no change, to improvement in client condition or functioning. The client's continuing need for care there is no limit on time the client is eligible for Home health care, therefore, the comprehensive assessment must clearly demonstrate the need, eligibility, for the home care benefit." Review of clinical record for patient 3 contained and Oasis (Outcome and assessment information set) with a start of care date of 11/29/2021, with a recertification period of 1/5/2022 through 3/5/2022, with diagnoses including but not limited to: Coronary Artery Disease (CAD - reduction of blood flow to the heart muscle due to build-up of plaque in the arteries of the heart) Diabetes Type 2 (DM - a chronic condition that effects the way the body processes blood sugar) and anxiety. Patient 3 was to receive HHA (Home Health Aide) services 2 hours per day, 2 days per week for 9 weeks and Skilled Nurse visits 1 hour a day once a week for medication set-up. The patient, "lives alone with no available caregiver...[spouse] passed away August of 2021 and [patient 3] has bouts of anxiety and depression...being treated for this with medication and reports that they do help some. [Patient 3] is alert and smiles with appropriate conversation...adds to conservation and is engaged in what we talk about. Cognitive: [patient 3] expresses complex ideas, feelings and needs clearly and completely with no impairment...sugars are well maintained...checks [his/her] {blood sugar levels} weekly...uses oral medication and diet to control sugars...Client verbalizes that [he/she] knows [he/she] misses some of medications and does not take them as prescribed ... All diagnoses are controlled with medications and/or treatments. Strength is [patient 3] is a motivated learner and compliant with MD orders. Weakness is depression and anxiety and loss of [patient's spouse]." This documentation in the clinical record failed to evidence patient deficits that required the intervention and services of a		reviewed if needed verbal ornotification orders were obtained and sent to physician forclarification. A section was added to our audit tool for Clinical staff to clearly demonstrate the continue need for home health benefit to ensure accuracy Clinical staff were counselled on G-532 and Policy 2.05 100% of new admissions and recertification will beaudited for adherence to this standard deficiency. Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible formonitoring these corrective actions and to ensure this deficiency does notrecur	

	skilled nurse for weekly Medi planner refills. An agency document titled "Case Conference" dated 1/4/2022, section titled "Notes" contained a handwritten entry, "Client called office voiced concerns about medications and knowing she is not taking them correctly. Educated client on importance of taking medications as prescribed, encouraged med set up by SN once weekly. [He/she] verbalized understanding and agreed to same. Will discharge from non-skilled and admit to Skilled care. MD aware." This document failed to evidence patient 3's deficits that required the intervention and services of a skilled nurse for weekly visits to refill the pillbox. In an interview on 1/20/2022 at 2:35 PM, the Clinical Manager indicated patient 3 does not have cognitive issues, does not have vision issues, and does not have manual dexterity issues. When queried as to patient 3's need for skilled nursing services, the Clinical Manager indicated patient 3 had missed a few doses of her medications. When queried if orders for patient medication education had been sought, the Clinical Manager stated, "No." During a home visit skilled nursing observation for patient 3 on 1/20/2022 at 9:30 AM, patient 3 was aware of the pending visit, upon arrival to the patient's home. The clinical manager made two attempts to get patient 3 to answer the door by knocking on the door and calling out for the patient by name through a screen door. The clinical manager was eventually able to reach the patient by telephone, who then came to the door to allow entrance into the home. Surveyor introduced self to patient and thanked patient for allowing surveyor to attend the visit, the patient looked directly at the surveyor, and smiled (patient squinted eyes while donning a surgical mask), patient 3 did not acknowledge the formal greeting made with a proper response. the surveyor and clinical manager had to raise their voices to communicate with patient 3 throughout the visit.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed	G0572	G-0572 The clinical staff educated/in-serviced on G-572 and policy 2.18, 2.12 and 2.37 to create a plan of care in	2022-02-08

	by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment for 5 (patients 1, 2, 3, 4, and 5) of 5 active records reviewed in a sample of 7. Findings include: 1. A review of an agency's policy titled, "Physicians Plan of Treatment Policy number 2.18," revealed, "1. A physician prepares a plan of treatment and it is made available to Heaven Sent ... 3. Physician's orders are established and documented ... for those patients/clients who: a. Are being actively treated, b. Have a health care need ... c. Are home Health Aide clients of a certified home health agency ..." A review of an agency s policy titled, 2.12 Verbal Orders, dated 1/29/2018, revealed, Policy: All medications, treatments, and services provided to patients must be ordered by a physician &will be signed dated and timed when received by & then faxed to physician for his/her signature &Purpose: To document verification that orders for services have been obtained from the physician. To assure accurate and complete orders are obtained and verified & A review of an agency's policy titled, 2.37 Record Contents," dated July 2018, revealed, "...3. Physician's Orders a. A verbal or written physician order is obtained prior to starting care. A verbal order is followed by a written order signed by the physician ... " 2. A review of the clinical record of patient # 2, revealed a start of care date of 1/17/22, which contained a "Non-Oasis SOC" (non-skilled assessment rather than an Outcome and Assessment Information Set, an assessment used to collect patient information for the start of care), dated 1/17/22; for the certification period		conjunction with the primary care physician Verbal orders obtained All records cited at survey have been corrected 100% of clinical records were reviewed if needed verbal or notification orders were obtained and sent to physician for clarification. A section was added to our audit tool for Plan of Care/Verbal Orders to ensure accuracy Clinical staff were counselled on G-572 and Policy 2.18, 2.12 and 2.37 100% of new admissions and recertification will be audited for adherence to this standard deficiency. Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

	health aide), 1 hour per day, 5 days per week. The clinical record revealed a "Plan of Care" document electronically signed and dated by the clinical nurse on 1/18/22, for the certification period of 1/17/22 to 3/17/22, which failed to evidence a physician signature. A review of the clinical visit notes revealed HHA made care visits on 1/18/22, 1/19/22, 1/20/22, and 1/21/22. The clinical record failed to evidence documentation of communication with the physician after the assessment, and prior to the furnishing care, to establish the plan of care. 3. A review of the clinical record of patient #4, revealed a start of care date of 3/8/21, which contained a "Non-Oasis Recert" dated 12/31/21, electronically signed and dated by the clinical nurse on 1/5/22; for the certification period of 1/5/22 to 3/5/22, with orders for HHA (home health aide), 1 hour per day, 5-7 days per week. The clinical record revealed a "Plan of Care" document electronically signed and dated by the clinical nurse on 1/5/22, for the certification period of 1/5/22 to 3/5/22, which failed to evidenced the physician's signature. Review of clinical visit notes evidenced the HHA furnished care visits on 1/5/22, 1/6/22, 1/7/22, 1/10/22 to 1/14/22, and 1/17/22 to 1/19/22. The clinical record failed to evidence communication with the attending physician, after the assessment, and prior to the first care visit to establish the plan of care. 4. A review of the clinical record of patient #5, revealed a start of care date of 1/13/22, which contained a "Non-Oasis SOC" for the certification period of 1/13/22 to 3/13/22, electronically signed and dated by the clinical nurse on 1/13/22; with orders for HHA 1 hour per day, 2 days a week.			

The clinical record revealed a "Plan of Care" document electronically signed and dated by the clinical nurse on 1/17/22 for the certification period of 1/13/22 to 3/13/22, which failed to evidence the physician's signature. T

A review of visit notes evidenced the HHA furnished care visits on 1/13/22, 1/14/22, and 1/18/22.

The clinical record failed to evidence documentation of communication with the attending physician,after the assessment and prior to the first care visit, to establish the plan of care.

5. A review of the clinical record of patient # 3, revealed a start of care date of 11/29/21, which contained a plan of care (485) for the certification period of 1/5/22 to 3/5/22, with orders for HHA (home health aide), 1 hour per day, 2 days per week and Skilled Nurse 1 hour per day, 1 day per week for medication set up. Review of the visit notes revealed HHA made care visits on 1/6/22, 1/10/22, 1/13/22, 1/17/22 and 1/21/22 and skilled nurse made visits 1/5/22 and 1/19/22.

The clinical record failed to evidence communication with the physician and the verbal orders to establish the plan of care.

In an interview on 1/20/2022 at 3:35pm with person E , nurse for doctor H s medical group ordering physician for patient 3, when queried about whether any phone calls had been received from Heaven Sent HH, LLC. person E states there were, no phone calls received recently and none previous to 11/24/2021, only faxes, no actual phone calls, no.

6. A review of the clinical record of patient #1, revealed a start of care date of 5/8/19, which contained a plan of care for the certification period of 12/23/21 to 2/20/22, with orders for HHA (home health aide), 1 hour per day, 3-5 days per week. Review of visit notes evidenced the HHA made care visits on 12/23/21, 12/24/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21,

	12/31/21, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/10/22, 1/11/22, 1/12/22, 1/13/22 and 1/14/22. The clinical record failed to evidence communication with the physician and the verbal orders to establish the plan of care. In an interview on 1/24/2022 at 2:35 PM, person F, with doctor I (primary care physician for patient 1) when queried as to whether agency nurse has reached out by phone to communicate with doctor or doctor s staff concerning obtaining verbal orders for patient 1, person F stated, not verbally usually, we get orders over the fax &I have not talked to them myself. IAC 17-13-1(a)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure services were provided only with physician authorization/approval in 5 of 5 active clinical records reviewed in a sample of 7. (Patients #1, 2, 3, 4, and 5) Findings include: 1. A review of an agency s policy titled, 2.12 Verbal Orders, dated 1/29/2018, revealed, Policy: All medications, treatments, and services provided to patients must be ordered by a physician &will be signed dated and timed when received by &then faxed to physician for his/her signature &Purpose: To document verification that orders for services have been obtained from the physician. To assure accurate and complete orders are obtained and verified & A review of an agency's policy titled, 2.37	G0580	G-0580 The clinical staff educated/in-serviced on G-580 and policy 2.12 and 2.37 to obtain verbal orders or a written order signed by the physician before starting care or recertification All records cited at survey have been corrected 100% of clinical records were reviewed if needed verbal or notification orders were obtained and sent to physician for clarification. A section was added to our audit tool for obtaining verbal Orders r a written order signed by the physician to ensure accuracy	2022-02-08

	"...3. Physician's Orders a. A verbal or written physician order is obtained prior to starting care. A verbal order is followed by a written order signed by the physician..." 2. A review of the clinical record of patient # 2, revealed a start of care date of 1/17/22, and contained a plan of care for the certification period of 1/17/22 to 3/17/22, with orders for HHA (home health aide), 1 hour per day, 5 days per week. A review of the visit notes revealed HHA made care visits on 1/18/22, 1/19/22, 1/20/22, and 1/21/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 3. A review of the clinical record of patient #4, revealed a start of care date of 3/8/21, and contained a plan of care for the certification period of 1/5/22 to 3/5/22, with orders for HHA, 1 hour per day, 5-7 days per week. A review of visit notes evidenced the HHA made care visits on 1/5/22, 1/6/22, 1/7/22, 1/10/22 to 1/14/22, and 1/17/22 to 1/19/22. review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 4. A review of the clinical record of patient #5, revealed a start of care date of 1/13/22, and contained a plan of care (485) for the certification period of 1/13/22 to 3/13/22, with orders for HHA 1 hour per day, 2 days a week. A review of visit notes evidenced the HHA made care visits on 1/13/22, 1/14/22, and 1/18/22. review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits.		Clinical staff were counselled on G-580 and Policy 2.12 and 2.37 100% of new admissions and recertification will be audited for adherence to this standard deficiency. Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

5. During a phone interview on 1/21/22 at 12:08 PM with person D, a nurse for doctor C for patient 2, stated that they hadn't received verbal order requests from Heaven Sent Home Care, they usually send a fax with their requests.

During a phone interview on 1/21/22 at 10:04 AM, with person B, a nurse for doctor A for patient 5, stated they had not had phone conversations with the agency this month and queried if the agency was supposed to call for verbal orders after assessments to obtain authorization for care visits.

5. A review of the clinical record of patient #3, revealed a start of care date of 11/29/21, which contained a plan of care (485) for the certification period of 1/5/22 to 3/5/22, with orders for HHA (home health aide), 1 hour per day, 2 days per week and Skilled Nurse 1 hour per day, 1 day per week for medication set up. Review of the visit notes revealed HHA made care visits on 1/6/22, 1/10/22, 1/13/22, 1/17/22 and 1/21/22 and skilled nurse made visits 1/5/22 and 1/19/22.

The clinical record failed to evidence communication with the physician and the verbal orders to establish the plan of care.

In an interview on 1/20/2022 at 3:35pm with person E, nurse for doctor H s medical group (ordering physician for patient #3), when queried about whether any phone calls had been received from agency nurse to obtain orders for home health services. Person E states there were, no phone calls received recently and none previous to 11/24/2021, only faxes, no actual phone calls, no.

6. A review of the clinical record of patient #1, revealed a start of care date of 5/8/19, which contained a plan of care for the certification period of 12/23/21 to 2/20/22, with orders for HHA (home health aide), 1 hour per day, 3-5 days per week. Review of visit notes evidenced the HHA made care visits on 12/23/21, 12/24/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21, 12/31/21, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/10/22, 1/11/22, 1/12/22, 1/13/22 and 1/14/22.

The clinical record failed to evidence communication with the physician and the verbal

	orders to establish the plan of care. In an interview on 1/24/2022 at 2:35 PM, person F, with doctor I (primary care physician for patient #1) when queried as to whether agency nurse has reached out by phone to communicate with doctor or doctor s staff concerning obtaining verbal orders for home health services for patient 1, person F stated, not verbally usually, we get orders over the fax &I have not talked to them myself. 7. In an interview on 1/19/2022 at 2:24 PM, Clinical Manager states she does not call physician after start of care, recertification to obtain verbal orders for home health services . She states all communication is through faxes, unless there are unusual findings during the visit then she will make a phone call to the physician. IAC 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to ensure the individualized plan of care was reviewed/revised by the ordering physician at the time of recertification of services in 3 (patients 1, 3, and 4) of 5 active clinical records reviewed in a sample of 7. Findings include: 1. A review of an agency s policy titled, 2.12 Verbal Orders, dated 1/29/2018, revealed, Policy: All medications, treatments, and services provided to patients must be ordered by	G0588	G-0588 The clinical staff educated/in-serviced on G-588 and policy 2.12 to obtain verbal orders or a written order signed by the physician before starting care or recertification All records cited at survey have been corrected 100% of clinical records were reviewed if needed verbal or notification orders were obtained and sent to physician for clarification.	2022-02-08

	that are part of the patient's plan of care, must be ordered by the physician &Purpose: To document verification that orders for services have been obtained from the physician. To assure accurate and complete orders are obtained and verified & 2. A review of the clinical record of patient #4, revealed a start of care date of 3/8/21, and contained a plan of care for the certification period of 1/5/22 to 3/5/22, with orders for HHA (home health aide), 1 hour per day, 5-7 days per week. A review of visit notes evidenced the HHA made care visits on 1/5/22, 1/6/22, 1/7/22, 1/10/22 to 1/14/22, and 1/17/22 to 1/19/22. A review of the clinical record failed to evidence the plan of care for the certification period of 1/5/22 to 3/5/22, had been revised/revised by the physician prior to the HHA care visit on 1/5/22. 5. A review of the clinical record of patient # 3, revealed a start of care date of 11/29/21, and contained a plan of care (485) for the certification period of 1/5/22 to 3/5/22, with orders for HHA (home health aide), 1 hour per day, 2 days per week and Skilled Nurse 1 hour per day, 1 day per week for medication set up. A review of the visit notes revealed HHA made care visits on 1/6/22, 1/10/22, 1/13/22, 1/17/22, 1/21/22, and the skilled nurse made visits 1/5/22 and 1/19/22. The clinical record failed to evidence documentation the attending physician had reviewed/revised the plan of care at the time of recertification of services.		A section was added to our audit tool for obtaining verbal Orders or written order signed by the physician to ensure accuracy Clinical staff were counselled on G-588 and Policy 2.12 100% of new admissions and recertification will be audited for adherence to this standard deficiency. Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

	In an interview on 1/20/2022 at 3:35 PM, with person E, nurse for doctor H s medical group (ordering physician for patient #3), when queried about whether any phone calls had been received from agency nurse to obtain orders to continue home health services. Person E stated, no phone calls received recently and none previous to 11/24/2021, only faxes, no actual phone calls, no. 6. A review of the clinical record of patient #1, revealed a start of care date of 5/8/19, and contained a plan of care for the certification period of 12/23/21 to 2/20/22, with orders for HHA (home health aide), 1 hour per day, 3-5 days per week. Review of visit notes evidenced the HHA made care visits on 12/23/21, 12/24/21, 12/27/21, 12/28/21, 12/29/21, 12/30/21, 12/31/21, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/10/22, 1/11/22, 1/12/22, 1/13/22, and 1/14/22. The clinical record failed to evidence documentation of communication with the physician to continue furnishing agency services. In an interview on 1/24/2022 at 2:35 PM, person F, with doctor I (primary care physician for patient #1) when queried as to whether the agency nurse has reached out by phone to communicate with the doctor or doctor s staff concerning obtaining verbal orders for home health services for patient 1, person F stated, not verbally usually, we get orders over the fax &I have not talked to them myself. 7. In an interview on 1/19/2022 at 2:24 PM, the Clinical Manager stated she does not call the physician the time recertification to obtain verbal orders to continue add, or remove home health services. She stated all communication was through faxes, unless there were unusual findings during the visit, then she will make a phone call to the physician IAC 17-13-1(a)(2)			
G0964	Coordinate referrals; 484.105(c)(3)	G0964	G-0964	2022-02-08

	Coordinating referrals, Based on record review and interview, the Director of Clinical Services failed to ensure coordination of patient referrals for hospitalization and failed to document consideration of referral for patients with fall risks for 3 (Patient #1, 2, and 4) of 5 active records in a sample of 7. Findings include: 1. A review of an agency's policy number 2.05 titled, "Comprehensive Assessment," dated 12/10/2019 revealed, "Purpose: Comprehensive assessment must be....consistent with the client's immediate needs,...Assessment of the clients current health status include relevant past medical history as well as all active health and medical problems & A review of an agency's policy number 2.30 titled, "Coordination of Care," dated 12/8/2019 revealed, "Purpose: To assure services are coordinated...and quality of care is being provided to clients...To provide the doctor with an ongoing assessment...and identify the clients response to services...Standard: Coordination of care...Integrate services...to assure identification of client needs and factors that could affect client safety and treatment...working with the client to recommend and make safety modifications..." A review of an agency's policy number 2.8 titled, " Hospital Risk Assessment Policy," dated 11/18/2019 revealed, "Purpose: The purpose of the policy is to establish the frequency of the assessment. Policy: The Hospital Risk Assessment has been adopted by Heaven Sent Home health Care as a screen tool to identify those patients at risk for hospitalization and thus as a guide for care planning..." 2. A review of the clinical record for patient #4 revealed a plan of care for the certification period of 1/5/22 to 3/5/22, evidenced diagnoses but not limited to chronic pain syndrome, hemiplegia (paralysis of one side of the body), history of falling, and cerebral infarction (occurs as a result of disrupted blood flow to the brain		The clinical staff educated/in-serviced on G-964 and policy 2.05, and 2:30 care coordination of referrals All records cited at survey have been corrected 100% of clinical records were reviewed if needed verbal or notification orders were obtained. Any additional services needed for patients were sent to physician. A section was added to our audit tool care coordination of referrals to ensure accuracy Clinical staff were counselled on G-964 and Policy 2.05 and 2.30 100% of new admissions and recertification will be audited for adherence to this standard deficiency. Any Adverse finding will be reported to QAPI Clinical Director and Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

indicated the patient was at risk for hospitalization. The plan of care indicated the patient's Functional Limitations were "endurance, contracture, ambulation, balance off due to weakness on left side,...and shuffling gait." Patient 4 lived alone in their own home and received home health aide services for 1 hour a day, 5-7 days a week, "for safety measures, keep pathways clear and well lighted, ask if any falls, assist with shower 5-7 days a week, assist with dressing, and light housekeeping".

The clinical record revealed a document titled, "Non-OASIS (a comprehensive assessment supporting the patient's need for services) Recert", dated 1/5/22, which revealed the patient was a fall risk - with a MACH 10 score: Risk 6, and identified stairs and torn carpet as a Safety hazard.

The clinical record evidenced a document titled, "Case Conference" dated 12/31/21, which failed to reveal the stairs and torn carpet as safety hazards were discussed, or consideration of a referral for patient 4 in relation to the identified high risk for falls.

A review of the clinical record evidenced a document titled, "Hospitalization Risk Assessment," dated 3/8/21, and revealed the patient had 6 boxes checked, indicating the patient was at high risks for hospitalization, indicating Therapy (Physical, Occupational, and/or Speech) and MSW (Master of Social Work), social worker referrals should be considered.

The record failed to evidence documentation of communicating the specific information of the hospitalization risk assessment to the physician, and failed to evidence consulting with the patient and the physician for Therapies and/or MSW evaluations.

3. A review of the clinical record of patient # 2, revealed a start of care date of 1/17/22, and contained a plan of care for the certification period of 1/17/22 to 3/17/22, which evidenced diagnoses but not limited to chronic pain syndrome and major depressive disorder. The patient lived alone in their own apartment and has orders for a home health aide, 1 hour per

day, 5 days per week for safety measures, ask if any falls, offer fluids, assist with shower 5 days a week, observes skin for changes, assist with dressing upper and lower body after showers, lotion after showers, incontinence care as needed.

The clinical record evidenced a document titled, " MAHC10-Fall Risk Assessment Tool," dated 1/17/22, which revealed the patient had a score of 6, indicating the patient was a fall risk.

The clinical record evidenced a document titled, " Hospitalization Risk Assessment," dated 1/17/22, which revealed the patient had 6 boxes checked, indicating Therapy (Physical, Occupational, and/or Speech) and MSW referrals should be considered.

The record failed to evidence documentation of communicating the MAHC-10 Fall Risk and Hospitalization Risk assessments to the physician, and failed to evidence consulting with the patient and the physician for Therapies and/or MSW evaluation referrals.

4. During an interview on 1/20/22 at 2 PM, with employees A (administrator)and B (alternate clinical director) regarding the "Hospitalization Risk Assessment," form that is completed upon assessments, both stated they hadn't realized the section where referrals should be considered was there.

5. A review of the clinical record for patient #1 revealed a plan of care for the certification period of 12/23/21 to 2/20/22, evidenced diagnoses but not limited to Type 2 diabetes, emphysema, and unspecified abnormalities of gait and mobility and indicated the patient was at risk for falls specifying incontinence, environmental hazards (small pet, pet toys, cluttered environment), Diagnosis (3 or more co-existing), polypharmacy (more than 4 prescriptions), prior history of falls within 3 months, and impaired functional mobility. The plan of care indicated the patient's Functional Limitations were "endurance, incontinence, and ambulation. The patient lived alone in their own home with no caregiver available and received home health aide services for 1 hour a day, 3-5 days a week for assist with bathing 3-5 days a week and light housekeeping.

	The clinical record revealed a document titled, "Non-OASIS (a comprehensive assessment supporting the patient's need for services) Recert", dated 12/20/21 revealed the patient Is a fall risk - MACH 10 score: 6 (risk). The clinical record evidenced a document titled, "Hospitalization Risk Assessment", dated 4/22/21 revealed the patient had a score of 7, indicating the patient is at high risks for hospitalization (any score above 5 was identified as high risk), indicating Therapy (Physical, Occupational, and/or Speech) and MSW (Master of Social Work), social worker referrals should be considered. The record failed to evidence documentation of communicating the specific information of the hospitalization risk assessment to the physician and failed to evidence consulting with the patient and the physician for Therapies and/or MSW referrals. 6. In an interview on 1/20/2022 at 3:50pm, alternate clinical manager (and member of Governing Body) stated she was unaware of the presence and use of the Michigan Alliance MACH 10 fall risk assessment found in patient s paper charts. Administrator states this was a new form initiated by the clinical manager.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE